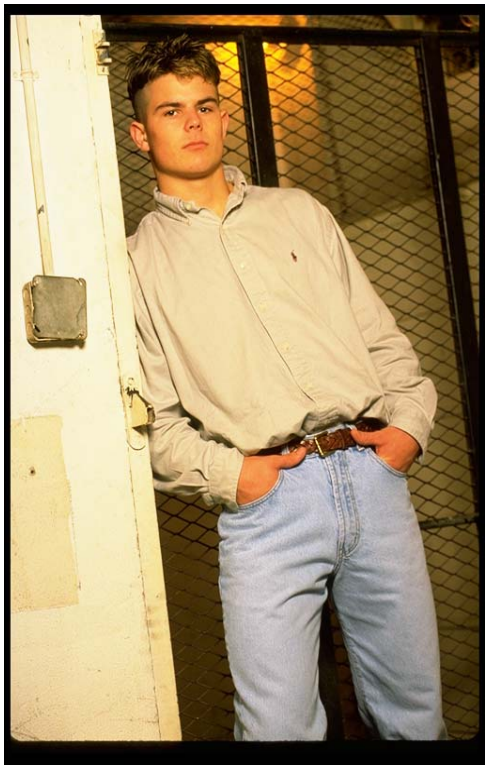
Unintended Pregnancy Prevention: Primary and Secondary

Team Report



Unintended pregnancy is not just a problem of individuals, but of public policies and institutional practices.

All pregnancies should be intended . . . consciously and clearly desired at the time of conception.
- Institute of Medicine, 1995

Spokane Regional Health District
May 2001

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The starting point of effective child abuse prevention is pregnancy planning.

-Everett Koop, 1986

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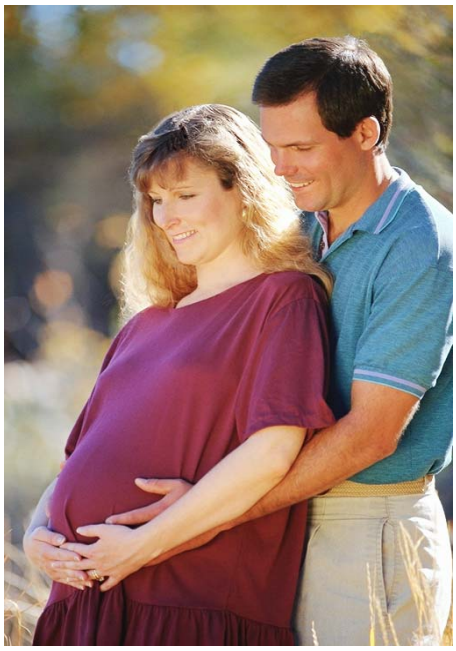
I. *Executive Summary*

In Washington State, 55 percent of all pregnancies and 40 percent of all births are unintended at the time of conception. While unintended pregnancies can result in healthy children and happy families, this is not always the case. Nearly half of all unintended pregnancies end in abortion. Compared with pregnancies that are planned, unintended pregnancy also increases health risks for women and children, causing it to be a serious public health problem.

In addition to its health impact, unintended pregnancy results in significant economic consequences that affect individual families as well as state health care support. In 1998, 62% of all publicly funded births were the result of unintended pregnancy, and the cost to taxpayers for all Medicaid-funded births in Washington State was estimated at $136 million.

The Unintended Pregnancy Prevention team has reviewed the literature, surveyed staff, gathered community input, and had numerous discussions around the prevention of primary and secondary unintended pregnancies to individuals in our community. The recommendations from the team fit within the three core functions of assessment, assurance, and policy development. In many ways, the first step to take in this initiative is to educate the public and Spokane Regional Health District staff around the whole concept of unintended pregnancy prevention. For some, this idea of "unintended pregnancy" is governmental jargon and does not resonate with them. For those of us who have worked in public health for many years, we understand the consequences of primary and secondary unintended pregnancies and the rationale behind reducing the rates to improve health outcomes and the money spent in our nation. This topic, as much as any other or more so, is laden with values, but if all pregnancies were intended . . .



Both teenage and non-marital childbearing would be reduced.

Poverty and welfare dependence would be reduced.

Abortion would be reduced dramatically.

II. Recommendations

Our mission at the Spokane Regional Health District is to serve as the region's public health leader and partner by demonstrating and advocating sound public health through policies, principles, and practices to promote health and protect the public.

The Public Health Improvement Plan states the core functions of public health as assessment, assurance, and policy development. The Unintended Pregnancy Prevention Team chose to organize our recommendations under these three headings.

Assessment:
Public health's role in assessment is to monitor the health status of the community, diagnose and investigate health problems, and inform and educate people about health issues. For unintended pregnancy prevention, we should:

- Assess Spokane County unintended pregnancy issues, including cultural beliefs and costs of unintended pregnancy, and research effective interventions for all males and young adults 18 to 24 years old;
- Develop and publish a document using current and new information on unintended pregnancy to build an understanding of the problem and issues in the community; and
- Increase assessment activities around reproductive health issues.

Assurance:
Public health's role in assurance is to enforce laws and regulations to protect health and safety; link people to needed personal health services; ensure a skilled public health workforce; evaluate effectiveness, accessibility, and quality of health services; and research and apply innovative solutions.

Areas that we could implement or strengthen within the Health District and in the community are:

1) Improve Knowledge about Unintended Pregnancy, Contraception and Reproductive Health. Components to consider include:
    - Education to clients and the community should be aimed at women of all ages, but men and boys deserve special emphasis.
    - All stakeholders should be considered sources of education and potential partners.
    - SRHD staff in some programs could do more around unintended pregnancy prevention, but need education themselves on feeling comfortable with sexual issues and current contraception methods. They also need the tools to use with clients, such as brochures and kits. A resource directory would help them make appropriate referrals internally and in the community. The role of current staff could be increased as we are missing opportunities to educate.
    - The awareness of available prevention/intervention resources in the community needs to be increased utilizing printed materials and media.

2) Increase Access to Contraception and Prevention Programs through:
    - ***Affordable clinical services*** providing a full range of reproductive health services should be available through a network of community clinics, Planned Parenthood clinics, and public health sites. These services are offered on a sliding-fee scale. Most sites should have special clinics for teenagers, drop-in hours, and interpreters for women and men whose first language is not English. We need to:
        - Broaden the range of health professionals promoting and providing birth control;
        - Include counseling for partners and couples on contraception usage;
        - Support the state emergency contraception availability effort; and
        - Provide family planning services at SRHD clinics by giving initial contraception than linking with community partners (see appendix D). Staff indicate that there are weekly missed opportunities to get a sexually active individual started on contraception while they are here for other services.

    - ***Community-based outreach*** by developing a network of organizations that provide family planning information and skills development, including abstinence, individual responsibility, risk-taking behavior, and contraception through individual and group contact. Specific programs that should be implemented or expanded include:
        - David Olds home visiting model (long-term involvement to reduce primary and secondary pregnancies);
        - Media campaign on unintended pregnancy to balance messages received by the public;
        - Support groups and mentoring programs for high risk youth using proven best practices, including females and males;
        - Continued emphasis on family planning in First Steps Programs and Community Service Offices; and
        - Technical assistance and training to schools and other community organizations around feeling comfortable and being current with sexuality information.

Policy Development:

Public health's role in policy development is to mobilize partnerships to solve community problems and to support policies and plans to achieve health goals. The Health District could take the lead in facilitating a community coalition around unintended pregnancy prevention to identify solutions with community partners.

We should advocate for policies and programs that address unintended pregnancy, such as:

- Comprehensive contraceptive services and supplies through private insurance and Medicaid public funding;
- Comprehensive school health education (CSHE);
- Private sector initiatives; and
- Public funding of prevention/intervention programs, including sexual abuse prevention, mentoring programs, parent education, and more.

Initial Action Steps to Begin Implementation of Recommendations:

- Fund a full time employee to coordinate and facilitate unintended pregnancy prevention activities within Spokane Regional Health District and in the community.
- Complete the assessment funded in 2001 on unintended pregnancy and publish a document to create an awareness in Spokane County. Samples of publications are available from other Washington local health jurisdictions. The document should be distributed widely. See Appendix E for summary of approved assessment.
- Develop and facilitate an unintended pregnancy prevention coalition to address community concerns, developing solutions to problems raised.
- Develop new partnerships and strengthen existing partnerships by meeting quarterly to network and increase linkages between programs and agencies. Initially, stronger linkages could immediately be made with the Community Service Organizations, Community Health Association of Spokane, and Planned Parenthood.
- Find funding to continue the teenage pregnancy prevention program support groups and to implement programs, such as the David Olds model. *See funding description below.
- Finish the directory of resources and distribute to staff and the community. Update the directory yearly.
- Hold trainings with SRHD staff on current contraceptive methods and increase their role in preventing unintended pregnancy. Programs that seem natural linkages include: Women, Infants, and Children (WIC); Clinics; Public Health Nurses Home Visiting; First Steps; Adolescent Health; Sexual Assault; Your Choice, Not Chance; AIDS; and Parent Child Assistance Program (PCAP).
- Implement the contraceptive starter kit for individuals coming to SRHD clinics for pregnancy, HIV, and STD testing. Couple and partner counseling/education should be provided.
- Provide technical assistance and training to stakeholders to increase the comfort level and quality of instruction on sexuality and contraception in the community.
- Begin working with the media around unintended pregnancy prevention issues.

**Funding: The Washington State Department of Health was asked to reduce their budget for the Governor. They chose to eliminate 10 of the 11 teenage pregnancy prevention projects that have been funded since 1994. The current plan is to utilize Temporary Aid to Needy Families (TANF) reinvestment funds to implement teenage pregnancy prevention programs, but will issue the funds through a new request for proposal process.*

Other sources of potential funding for unintended pregnancy prevention that have come to the forefront include: Ms. Foundation, Public Welfare Foundation, and Group Health Cooperative Foundation. The Health Improvement Partnership has agreed to administering funds through their 501 (C) 3 status to assist us in resource development. Unintended pregnancy prevention fits with many of their initiatives, such as youth development, childcare, and America's Promise.

III. Introduction and Background

A general consensus exists among public health agencies over the desire to reduce unintended pregnancies, abortions, and teen pregnancies, but the programs and policies that should be supported remains controversial. Research suggests that many factors contribute to the high rate of unintended pregnancies in the United States, including reduced access to contraceptives, low expectations among poor women, high levels of risk-taking behavior, the failure of the media to encourage responsible attitudes toward sexual activity and reducing pregnancy risk, and more. To effect change will require development of a community consensus around both the importance of reducing unintended pregnancies and the best strategies for achieving a reduction. The debate surrounding programs to reduce teen pregnancy is a good illustration. While many people support programs, which include abstinence, contraceptive information, and sexuality education, others are opposed to anything but exclusively abstinence-based programs. A discussion of best practices is included in this report to demonstrate what the literature and research says works. The challenge remains to build public support for effective programs to make an impact in the unintended pregnancy rates. There is no single cause, no single or simple answer, and no one organization responsible to solve the problem – it is an issue that truly needs a comprehensive, multi-pronged community response.

The Health Officer at the Spokane Regional Health District (SRHD) formed a team of staff to look at issues around reproductive health in May 2000. The members on the team are listed below. Originally, the team started their discussion around teenage pregnancy issues, but soon expanded the work to include unintended pregnancy prevention, primary and secondary. Over the years, research, funding, and prevention efforts have been focused mainly around teenage pregnancy, although data has been kept on the health of mothers and infants due to unintended pregnancy to women of all ages.

The definition of ***unintended pregnancy*** is a pregnancy that a woman considers either mistimed (occurring earlier than desired) or unwanted at the time of conception.

Our team defined ***unintended pregnancy prevention*** as the prevention of primary and secondary pregnancies to women of all ages – teens (12-19 years of age) and adults (20 and over). Secondary prevention includes those individuals who have been pregnant, regardless of the outcome (aborted, miscarried, parenting, or relinquished). Our efforts did not focus on pregnant women.

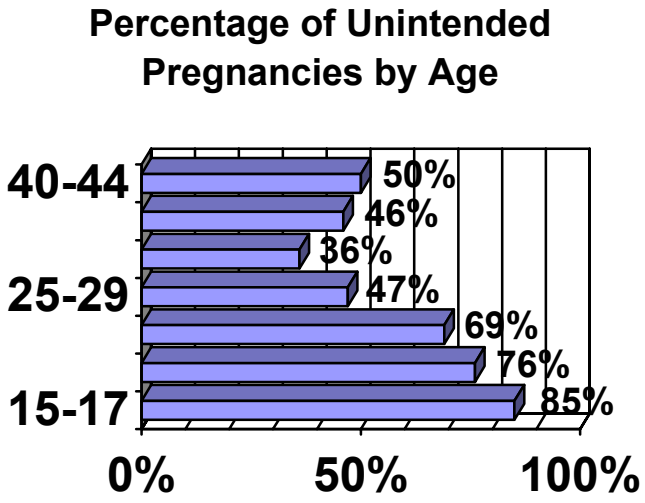
The team outlined their tasks over the next year into four areas:

Task I:	Research SRHD current activities in primary and secondary pregnancy prevention.
Task II:	Research community agencies that provide primary and secondary pregnancy prevention services.
Task III:	Identify gaps in services, potential collaborations and expansion of services, and internal links between services.
Task IV:	Develop the ideal community system for primary and secondary pregnancy prevention.
Task V:	Write a report and submit with recommendations to Executive Team.

IV. The Statistics Reflecting the Issue

In an era when technology should enable couples to have considerable control over their fertility, over half of all pregnancies (6.3 million) in the United States are unintended. From the Washington State Department of Health's First Steps Database report in June 1997, more than half (55%) of all pregnancies in Washington State are unintended at the time of conception. While the rate of unintended pregnancy in Washington State is similar to that for the United States, many developed countries have much lower rates of unintended pregnancy, abortion, and teen pregnancy. Reducing unintended pregnancy is a public health goal at both the state and national levels. See appendices B and C.

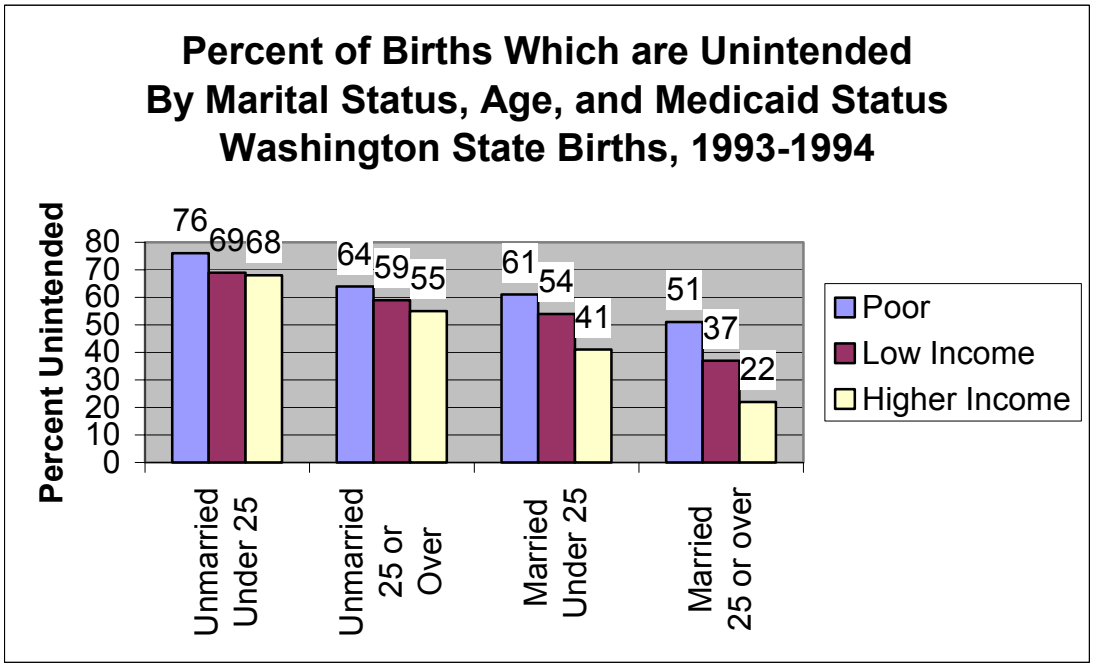
- The majority (58%) of unintended pregnancies in the state of Washington occur to women in their twenties.
- While the abortion rate for young teens in Washington State is now lower than their birth rate, most (85%) 15 to 17 year old teens who become pregnant did not want to become pregnant when they conceived.



- Mothers under 20 years of age have the highest percentage of births resulting from unintended pregnancy, but actual numbers are highest among 25-29 year olds.
- Of the 40 percent of births that were unintended, 60 percent of those were to women who were married.
- While one-third of births to married women were unintended at conception, two-thirds of births to unmarried women were unintended at conception.
- More than two-thirds of births to poor women were unintended at conception, while less than one-third of births to higher income women were unintended.
- Age, marital status, and income are each related to pregnancy intention, with marital status the most important factor.
- Among unmarried women, more than half of all births were unintended for all major age and income groups, even among higher income women over 25 years old.

- Women with the lowest incomes had the highest rates of unintended pregnancy resulting in birth with 57.7 percent in 1997 as compared to 26.3 percent of women with the highest incomes. This is based on those eligible for Medicaid coverage.
- Among White and Hispanic women, 40% of pregnancies are unintended, while African American women have an even higher rate of 70%.

Washington State Department of Health proposed state-specific year 2000 goals in *The Health of Washington State.* By the year 2000, DOH proposed that less than 30 percent of births should be the result of unintended pregnancies.



Only higher income married women over 25 years old met the Washington State Department of Health year 2000 goal for less than 30 percent of births to be unintended.

The Healthy People 2010 objective is to increase the proportion of pregnancies that are intended to 70 percent. The baseline they use is 51 percent of all pregnancies among females aged 15 to 44 years were intended in 1995. The objectives for Healthy People 2010 echo the recommendations contained in the 1995 Institute of Medicine report *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families.* The foremost recommendation of the report calls for the nation to adopt a social norm in which all pregnancies are intended – that is, clearly and consciously desired at the time of conception. Emphasizing the personal choice and intent, this norm speaks to planning for pregnancy including the spacing of children for optimal health, as well as avoiding unintended pregnancy.

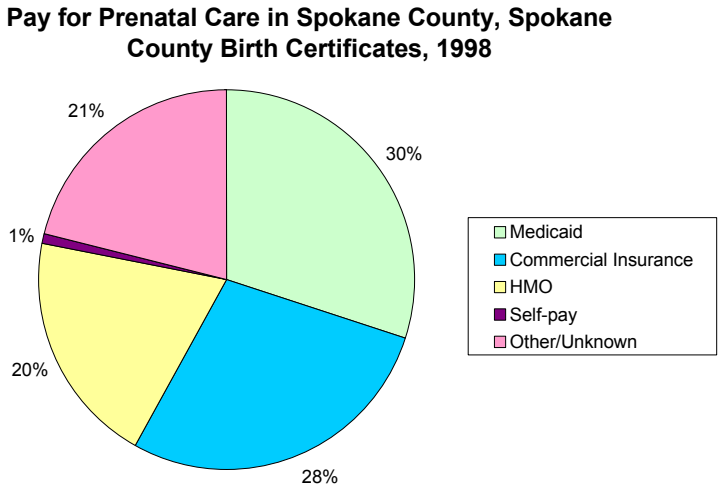
Unintended pregnancy in the United States is serious, costly, and occurs frequently. Socially, the costs can be measured in unintended births, reduced educational attainment and employment opportunity, greater welfare dependency, and increased potential for child abuse and neglect. Economically, health care costs are increased. An unintended pregnancy, once

it occurs, is expensive no matter what the outcome. Medically, unintended pregnancies are serious in terms of the lost opportunity to prepare for an optimal pregnancy, the increased likelihood of infant and maternal illness, and the likelihood of abortion. The consequences of unintended pregnancy are not confined to those occurring in teenagers or unmarried couples, but can carry serious consequences at all ages and life stages.

With an unintended pregnancy, the mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all. She is less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco or alcohol. The child of an unintended pregnancy is at greater risk of low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development. A disproportionate share of the women bearing children whose conception was unintended are unmarried or at either end of the reproductive age span – factors that carry increased medical and social burdens for children and their parents.

For teenagers, the problems associated with unintended pregnancy are compounded, and the consequences are well documented. Teenaged mothers are less likely to get or stay married, less likely to complete high school or college, and more likely to require public assistance and to live in poverty than their peers who are not mothers. Infants born to teenaged mothers, especially mothers under age 15 years, are more likely to suffer from low birth weight, neonatal death, and sudden infant death syndrome. The infants may be at greater risk of child abuse, neglect, and behavioral and educational problems at later stages.

The pregnancy care cost for one woman who does not intend to be pregnant, yet is sexually active and uses no contraception, is estimated at about $3,200 annually in a managed care setting. Estimates of the overall cost to U.S. taxpayers for teenage childbearing range between $7 billion and $15 billion a year, mainly attributed to higher public assistance costs, foregone tax revenues resulting from changes in productivity of the teen parents, increased child welfare, and higher criminal justice costs.



As demonstrated by the pie chart, 30% of births are paid for in Washington by Medicaid with an additional 21% other, which includes some unknown and the state subsidized Basic Health Plan and Healthy Option programs. The State of Washington First Steps Database reports 2,413 Medicaid-paid births (44%) in 1998 utilizing Maternity Support Services and Maternity Case Management in Spokane County. This is 3 percent higher than the state average. Another report indicated that Medicaid in Washington paid for 70% of births to women 15-24 years of age in 1997.

Each year, publicly subsidized family planning services prevent an estimated 1.3 million unintended pregnancies. For every $1 spent on publicly funded contraceptive services, $3 is saved in Medicaid bills for pregnancy-related health care and medical care for newborns. Another report demonstrated the impact of public funding in Washington showing for every $1 spent on family planning $7 would be saved on women ages 10-40, $12 on teens, and $73 on women seen in publicly funded clinics. A recent study in the *American Journal of Public Health* evaluated the clinical and economic impacts of 15 contraceptive methods. The study found that all 15 methods were more effective and less costly than no method. The most effective methods would in fact each save over $13,000 per person and prevent approximately 4.2 pregnancies per person over a 5-year period. Total public expenditures for family planning declined by one third between 1980 and 1992. Federal funding declined 72%.

Induced abortion is another consequence of unintended pregnancy. Although the numbers of abortions in this country have been declining over the past 15 years, approximately one abortion occurs for every three live births annually in the United States, a ratio two to four times higher than in many other Western democracies. By reducing unintended pregnancies, we are reducing the number of abortions.

In the past, pregnancy prevention efforts have focused strongly on the teenage population. Pregnancies to teenagers in Spokane County have seen dramatic declines over the past 20 years. In 1999, 33.0/1,000 teenagers 15 – 17 years old became pregnant compared to 55.2/1,000 in 1978, the highest point in the 21 years. The 33.0 rate is still higher than many other industrial countries. Issues around teenage pregnancy often get laden with discussions on values and morals, but more than half of 17 year olds have had intercourse. Studies have also discovered that 66% of pregnant teens were sexually abused and that 29% of partners for 15-17 year old women are 3-5 years older with another 7% more than 6 years older. The issue becomes cloudy with factors separate from the ideal world and the world these teens are growing up in. Teenagers are found to be better contraceptors than individuals in their twenties. Ninety percent of teenagers use contraception, but not always consistently or correctly. A survey conducted by the Spokane Regional Health District in 1997 reported that teenagers perceived two main barriers to using contraception, wanting lower cost (54%) and more places to get it (34%). Most researchers agree that unintended pregnancy rates and teen pregnancy rates have been on a continuous decline due in part to increased access to and use of contraceptives, increased education and awareness, and decreased sexual activity among teenagers.

If all pregnancies were intended, both teenage and non-marital childbearing would be reduced; poverty and welfare dependence would be reduced; and abortion would be reduced dramatically.

V. Spokane Regional Health District Staff Input

Survey Results

A survey to obtain information on pregnancy prevention services from staff at the Spokane Regional Health District was distributed in the summer of 2000. The survey was distributed to all staff in Community and Family Services, Health Education and Promotion, the Laboratory, Substance Misuse Services, and Vital Records. A total of 175 surveys went out with thirty-three (33) staff or 19% responding. Twenty-eight (28) of the 33 staff provided some type of pregnancy prevention service.

The majority of services provided by staff described in the survey included pregnancy prevention/STD/contraceptive methods counseling providing one-on-one or group education, videos, written materials, and demonstrations or model kits (30); referral to contraceptive services in community or SRHD clinic (pregnancy testing, pelvic exams) (16); and providing access to free condoms (9) with some demonstrating use. Three provided goal setting (short and long term) discussions with clients, two followed up on chosen birth control methods, one provided partner notification, one interpreted for First Steps and Refugee Screening in Russian, and one provided education to community. Programs mentioned by survey respondents included the Parent-Child Assistant Program (PCAP) which has a family planning component serving 45 females; the Life Skills classes for youth in the juvenile justice system; peer education programs; and the teen pregnancy prevention program providing support groups and mentoring high-risk females. One staff commented that they would like to be able to provide birth control, not just refer.

Staff refer clients to the following SRHD services: Clinic for STD, HIV, and Pregnancy testing (14); Your Choice, Not Chance program (14); public health nurses (8); Maternity Support Service/First Steps program (6); AIDS program, including the peer education group (Youth Awareness KORP) (4); free condoms (2); adolescent health program (1); and Family Support Services (1).

Staff refer clients to services in the community, including: Planned Parenthood (26); Private Physicians (23); Community Clinics (21); *SRHD Clinic for pregnancy/STD/HIV testing (19*); Community Service Offices (12); Life Services (8); Hospital Services, including sterilization (1), Sacred Heart Obstetric clinic (1), and Deaconess Women's Clinic (3); Teen-Aid (5); *public health nurses* (1); Children and Parenting Alone (1); pharmacies for emergency contraception (1), and the Children Requiring A Caring Kommunity (CRACK) program (1). Some staff referred to SRHD services in this question on the survey, also.

Staff felt additional services in the community would be beneficial in the following areas:

Education

- School-based programs (updated information, consequences of teen pregnancy and the responsibilities, abstinence) (7)
- Costs of raising children vs planning (4)

- Continual information to everyone regarding birth control methods and effectiveness/taking as prescribed at any visit to a medical facility or social service appointment (2)
- A statewide education of pharmacies and pharmacists to put them in compliance with offering birth control regardless of private or state pay coverage.
- Open, honest discussions about sexuality, sexual behavior, and choices
- Accountability trainings
- Pre-pregnancy planning (folic acid, risk behaviors like smoking, alcohol, illicit drugs, prescription drugs and over-the-counter meds)
- Male programs
- Resource information on services, providers, access (3)

Media:

- Public announcements on TV (abstinence) (2)

Services:

- Affordable and comprehensive contraceptive services linked to complete reproductive health services (options, effectiveness, how to use, supply of contraception, STD/HIV disease prevention counseling, testing, diagnosis, and treatment) from all HMO's, clinics, and private physicians (14):
  - ◊ A program that is non-political (not Planned Parenthood, not Crisis Pregnancy Center) to refer clients to (some women, teens, medical professionals, and staff have strong opinions about referring to these)
  - ◊ Easier access - (SRHD would be a great place)
  - ◊ Insurance coverage of birth control (5) and free/sliding fee scale (4)
  - ◊ Free condoms
  - ◊ More reproductive health care services for men and male youth - big missed opportunity
  - ◊ Free HIV testing no matter risk factor or group
  - ◊ Confidentiality and non-judgmental counseling for prevention of pregnancy, STDs, HIV
  - ◊ Incentives to not get pregnant ($, prizes)

Staff see the public health role as providing any measures to preventing pregnancy by linking with clinics that provide full reproductive health services, including contraceptive counseling and a full spectrum of contraceptive methods and options. One staff asked, "Should we be the "non-political" source for information, contraceptives, pregnancy testing?" Another said public health should "remain non-judgmental and non-threatening - not judge people's values." (4)

Staff wanted to assure that health educators, public health nurses, and other staff had educational materials to take to families or give to clients, including the WIC office (2). More education or trainings were mentioned as needed on the problems associated with unwanted pregnancy; prevention programs for teen males; education in public/private schools (STD, HIV, pregnancy prevention) (3); public education on needing easier access to birth control and insurance coverage; safer sex and abstinence (2); resources available (4); and community education on folic acid and other pre-pregnancy issues. Working with the

schools on updating their information/materials was mentioned as some school districts use outdated textbooks, handouts, and videos.

A media campaign similar to drug abuse reality training could be provided by public health as well as more ads on the problems associated with unwanted pregnancy for a life time.

The public health services desired included: Birth control services, including Depo shots (not Norplant, unless experienced with product); some form of birth control method available when teens visit STD clinic and indicate need; free and sliding fee scale for birth control (3); birth control accessible at all community centers; referral and written information preparing client for exam and choices; pregnancy testing; STD/HIV testing and education for all people; and medication to treat STDs in both partners at sliding scale to no charge, if need be.

Staff would like current information about pregnancy prevention programs and activities at SRHD and in the community - listing who qualifies, cost, contact information, birth control options at site, and insurance coverage (8); educational materials to take to families; office set up to handle clients requesting information or needing assistance; one hour update on current contraceptive trends; an idea of gaps in service; funds for birth control methods, including permanent sterilization for clients; and samples of birth control to discuss with clients. One staff felt that current resources were not being utilized.

Cultural Perspective of Clinic Staff

The literature indicates that various cultures have religious and personal beliefs that impact their utilization of family planning services and thinking. The Unintended Pregnancy Prevention Team asked the clinic staff to provide a write-up on their perspective of cultural issues observed in the clinic effecting pregnancy prevention. An assessment is being held this year to further understand this issue through focus groups with various cultural groups in our community.

In Spokane, we have a very large Russian/Ukrainian population. Most of these people came here under a refugee status, and are from Northern Russia. They generally practice Pentecostal Baptist Religion. Together with their husbands, they believe God gives and takes life, and are not usually open to any discussions regarding pregnancy prevention. Having many children they believe is also protective in their old age, as daughters will care for older, sick parents. To them, it is easier to care for many children than to work or go to school. There has been no education regarding the possible physical and emotional effects of multiple pregnancies at close intervals. If a family doesn't have children, it is believed it may be a deserved punishment from God.

The husband or the woman's mother make most of the family decisions. IUD's are considered sinful according to their religion. Some may agree to Depo-Provera, if their husbands approve and consider this safer than birth control pills. This is usually when there have been several cesarean sections, previous pregnancy and delivery complication, and some chronic conditions.

Some other cultures in our community are the Vietnamese, Bosnians, Hispanics, and Hmong. Vietnamese seem to be open-minded in general to new ideas, but may lack previous education and information. Bosnians are generally up to date with modern technology on all methods, although they may not have had access to services. Hispanics also may not have had access or education, but appear open minded. Hmong do not appear to be open to modern ideas regarding pregnancy prevention and have large families.

All cultures and subcultures may have very diverse beliefs and ideas on pregnancy prevention. This may be culturally, religiously, or educationally driven. People with higher education tend to be open-minded to new ideas and technology.

VI. Community Stakeholder Input

On January 30, 2001, a community forum was held to gain input on unintended pregnancy prevention issues in Spokane County. About 400 letters were sent out to individuals at businesses, churches, healthcare, media, political offices, schools, public and voluntary agencies. Over 60 individuals attended the forum representing diverse views on the issue.

A presentation was given on the issues surrounding unintended pregnancy, including the numbers, consequences, and costs. The Unintended Pregnancy Prevention Team members led the group through a series of exercises to understand the following:

- Who are the community stakeholders around unintended pregnancy prevention?
- What role should each stakeholder in the community play in unintended pregnancy prevention?
- What areas need the greatest improvement to prevent unintended pregnancy in our community?

The compilation of their responses is available separate from this report. Their information was utilized to complete the Ideal Unintended Pregnancy Prevention System on page 20 and Summary of Identified Gaps in Community on page 24. In our discussion at the forum, areas of concern that came out the strongest included:

- Increasing access to comprehensive healthcare services
- Increasing individual and community education on unintended pregnancy prevention
- Increasing prevention programs targeting the male
- Strengthening an emphasis on individual responsibility
- Working with the media on balanced messages

After the forum concluded, individuals turned in interest forms indicating whether they wanted the minutes from the meeting and/or wanted to participate in a coalition to address the issues raised.

Additional Community Information

The Medical Assistance Administration/Family Planning, Economic Services Administration/CSD, and Department of Health conducted community meetings in Eastern Washington in 2000. Common themes from the community meetings across Region I were compiled in a report titled, *Establishing a Community Continuum for Family Planning/First Steps Service Delivery in Region 1*. The themes were categorized under the following areas: Access to Methods; Attitudes (largest category including the health care provider and women/family attitudes about family planning); Counseling Barriers (clients need instructions for birth control explained several times and may need to be shown); Cultural Context (attitudes and knowledge specific to cultures); Family Planning Marketing and Materials (lack of awareness around family planning services); Outreach and Education (clients hold myths and misinformation about birth control/community partners are not aware of resources and/or current methods); Pharmacy Issues (lack information regarding family planning coupons and billing and/or do not provide birth control instructions thoroughly to clients).

VII. What the Research Says Works

A REVIEW OF THE LITERATURE
Programs and Practices

The purpose of this section is to provide a brief review from the literature of programs and approaches that have been found to be effective in impacting the problem of unintended pregnancies.

I. Adolescents

An unintended pregnancy is one that a woman considered either mistimed or unwanted at the time of conception. Although the problem affects all segments of society, not just teens and unmarried women, it is of particular importance among adolescents. Franklin and Corcoran in their article "Preventing Adolescent Pregnancy: A Review of Programs and Practices" reviewed literature on numerous programs for adolescent pregnancy prevention. Outcome research defines some of the "best practices" to provide guidance regarding program components and curricula. The following conclusions are offered for the purpose of guiding practice:

- Clinic programs have been found to be more effective than other types of pregnancy prevention programs.
- Community-based clinics are more effective than school-based clinics. School-based clinics, however, are more effective than other sex education programs.
- Including contraceptive knowledge building and distribution is an essential component for developing an effective program.
- An effective pregnancy prevention strategy, however, requires more than just contraceptive distribution. Comprehensive sex education and skills training must be a part of the program. Full attention must be given to age and developmental issues when developing prevention programs and curricula.
- Sex education curricula based on social learning theory and skills training are more effective than other types of curricula, and should be used as interventions in programs.
- Psychosocial problems that complicate development also require additional interventions beyond standard sex education programs and curricula. Substance abuse and sexual abuse, for example, put adolescents at risk of early pregnancy and involve more complicated psychological and developmental issues.

In 1999 the Washington State Department of Health published "Lessons Learned: Five Years of Teen Pregnancy Prevention Community Projects." This report is a compilation of lessons learned during the initial five years of teen pregnancy prevention community projects in Washington State. The lessons learned include:

- Program Planning: Planning and developing successful projects involves bringing together stakeholders and decision-makers to work collaboratively and create a shared vision.

- Program Participants: Successful programs involve a coalition of teens, parents, community advisory members and project staff in planning and implementation of strategies and activities.
- Establishing and Maintaining School-Community Partnerships: Establishing and maintaining partnerships has been one of the most critical tasks for the project. These relationships are crucial to a project's success and not only help keep projects visible and viable, but also serve to get at-risk teens involved in activities.
- Interventions and Activities: Programs showing some promise of reducing teen pregnancy include multiple components that address teen sexual behavior and risk factors, including poverty, lack of opportunity and family dysfunction.
- Family Planning: Teen pregnancy prevention programs that include access to family planning services are more likely to be successful.
- Overcoming Barriers: Preparing a pro-active plan among program administrators and advisory group members helps to deal with community opposition, should it arise.
- Evaluation: On-going, rigorous and systemic evaluation ensures that program goals are being met and that changes are implemented as needed

A local program example is Spokane's *Your Choice, Not Chance* Program, which provides community-based support groups offering education, peer support, recreation, advocacy, links to clinical family planning services, and a mentor match.

The "Lessons Learned" report indicates that "while energy-and labor-intensive, individual and collective efforts by project staff and communities are helping teens create healthier lifestyles and make wiser choices that reduce risk-taking behaviors and change attitudes to avoid early pregnancy and childbearing."

Singh and Darroch in their article, *Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries*, conclude that the trend toward lower adolescent birthrates and pregnancy rates over the past 25 years is widespread and is occurring across the industrialized world, suggesting that the reasons for this general trend are broader than factors limited to any one country: increased importance of education, increased motivation of young people to achieve higher levels of education and training, and greater centrality of goals other than motherhood and family formation for young women. For example, Sweden's success in reducing teenage pregnancy rates and birthrates is credited to both improved sexuality education and improved provision of contraceptives to adolescents. More generally, the European approach to teenage sexual activity, expressed in the form of widespread provision of confidential and accessible contraceptive services to adolescents, is viewed as a central factor in explaining the more rapid declines in teenage childbearing in northern and western European countries, in contrast to slower decreases in the United States.

II. Insurance Coverage

A major cause of unintended pregnancy is failure to access and use contraception properly and consistently. Having private health insurance does not necessarily guarantee access to family planning services.

As stated earlier, unintended pregnancies impact women of all ages from all segments of society. As more and more Americans enroll in managed care health plans, it becomes increasingly important to look at how they address the issue of unintended pregnancy prevention. Although managed care plans emphasize their commitment to preventive care, the extent to which preventing unintended pregnancy is included in their concept of such care is unclear. In an article "Managed Care and Unintended Pregnancy: Testing the Limits of Prevention" the authors quote from the Institute of Medicine, which issued a major report on this issue in 1995, stating that "the problem of unintended pregnancy is as much one of public policies and institutional practices as it is one of individual behaviors." This article also refers to a study from the National Survey of Family Growth and the National Maternal and Infant Health Survey which suggested steps to increase access to family planning services, including standardizing the types of family planning services available under all health insurance policies, increasing the availability of more effective prescription-based methods, removing financial barriers such as co-payments, formally classifying family planning as a preventive service, and devoting more public funding to family planning services. Another area of concern is confidentiality. Under the claims system of indemnity insurance, dependents may have difficulty obtaining confidential services if a policyholder signature is required on a claim form or if the Explanation of Benefits is sent to the policyholder. Confidential services are more likely to be obtained in HMO's, which typically do not use claim forms since care is prepaid. Managed care plans have reportedly demonstrated improvements in contraceptive coverage and in confidentiality protections.

Medicaid provides a major source of public funding for contraceptive services and supplies. Medicaid managed care programs must contain a freedom-of-choice provision for family planning providers. Although some of these providers are compensated directly by the state, others must seek reimbursement from the managed care plans; without formal contracts, these providers can go unpaid. Some family planning agencies, such as Planned Parenthood, community health centers, and school-based clinics have entered into collaborative arrangements with managed care with varying degrees of success.

III. Washington State's Efforts – Medicaid Population

In the early 1990's, Washington State started a pilot program in 5 sites to bring family planning services into the Department of Social and Health Services Community Services Offices (CSO's) to increase access to these services by low-income Medicaid clients. In 1994 family planning services were introduced into the remaining CSO's. Washington State mandates family planning assistance and information for all Temporary Assistance for Needy Families (TANF) clients as an essential component of helping them become and maintain their self-sufficiency (RCW 74.12.400 and 410). The specific direction and emphasis of CSO programs may vary, allowing CSO's and their contracted family planning agencies to design their own programs based on their community needs. For example, some focus on home visits and outreach; others have onsite family planning clinics. "Family Planning in

Washington Community Services Offices: Challenges and Strategies" states that respondents in the five original sites reported that family planning was effectively integrated into their CSO's and suggested that program efforts be enlarged. They identified that broader support at all levels, including regional and state level administrators, is necessary to increase successful efforts to provide family planning services to this vulnerable population.

IV. Secondary Unintended Pregnancy Prevention

David L. Olds, Ph.D. has researched a program of prenatal and infancy home visitation by nurses. Typically nurses work with families in their homes during pregnancy, and the first two years of the child's life. The program is designed to help women improve their prenatal health and outcomes of pregnancy; improve the care provided to infants and toddlers in an effort to improve the children's health and development; and improve women's own personal development, giving particular attention to the planning of future pregnancies, women's educational achievement, and participation in the work force. In a 15-year follow-up study of subjects in Elmira New York, findings showed that low-income and unmarried women provided a nurse home visitor, in contrast to those in a comparison group, had 31% fewer subsequent births as one of the positive outcomes. This model has been published as being one of the only programs that has been successful in reducing secondary pregnancies.

In addition, as a secondary unplanned pregnancy prevention measure, Washington State has implemented a performance measure in all of its Medicaid First Steps Maternity Support Services Programs. The desired outcome is for the client to be using birth control by six weeks postpartum. Nurses and social workers are providing preventive health services to these women during both the prenatal and postpartum period, so are in a unique position to promote positive outcomes. Staff work with the clients on short and long term goals for their life, including the spacing of and planning for children.

VIII. Ideal Unintended Pregnancy Prevention System

Community Stakeholders' Key Roles

Businesses should:
Be involved in community issues
Provide adequate wages with health insurance coverage
Provide resources to employees
Provide holistic wellness programs
Support families with flexible polices
Support prevention programs

Childcare should:
Link parents with community services
Model positive adult-child interaction and open communication
Obtain national standards of quality care
Provide educational materials for parents
Provide parenting classes and support

Faith Organizations should:
Encourage abstinence and responsible behavior
Hold open discussion and provide education around sexuality issues
Promote healthy families
Provide counseling and support groups to members
Provide positive activities for individuals and families
Refer individuals to comprehensive family planning services
Support community programs

Families should:
Communicate on sexuality issues between adults and with children
Convey values around sexual behavior
Limit and/or monitor computer and television use
Obtain and provide accurate information around sexual health
Obtain medical coverage
Provide positive role modeling and parenting practices
Provide supervision from infancy through adolescence
Seek medical care for all family members
Structure positive individual and family activities
Support family members

Individuals should:
Abstain from having sexual intercourse until ready
Advocate for programs/services supporting pregnancy prevention
Be a role model for others
Educate self on sexuality issues
Get involved in positive activities
Obtain healthcare, family planning, and support services

Respect self and others
Support peers' choice of abstinence
Set goals and plan for future
Take responsibility for actions

Legislators should:
Become informed on reproductive health issues and respond to the issues
Fund prevention programs
Pass legislation to increase access to family planning services and healthcare coverage for all, including comprehensive reproductive health services
Support educational reform to provide comprehensive school health education, including sexuality education

Media should:
Accurately report issues around sexual behavior
Eliminate negative sexuality messages
Promote abstinence and responsibility
Provide information on family planning and other reproductive health services
Report effective prevention programs
Show images leading to positive sexual health
Take responsibility to stop glamorizing and sensationalizing sex

Primary Care should:
Eliminate barriers to obtaining family planning services
Identify high-risk individuals and provide outreach and follow-up care
Provide comprehensive education and counseling on pregnancy prevention
Provide non-judgmental comprehensive reproductive healthcare services
Support community prevention programs
Teach parents to be sexuality educators

Public Agencies should:
Advocate for and implement best practice prevention programs in the community
Continue to assess unintended pregnancy
Demonstrate the benefits to individuals to plan for their future
Provide education on comprehensive reproductive health issues, including available resources
Provide public service media campaigns
Provide or assure access to healthcare, family planning services, and support services
Provide outreach services to high-risk populations

Researchers should:
Continue research on best practices for different populations
Continue research on effective birth control methods for males and females
Educate public on the costs of prevention versus intervention
Explore root causes behind unintended pregnancies, including cultural, religious, and personal beliefs
Publish the relationships between unintended pregnancy and other societal issues, such as child and sexual abuse

Schools should:
Encourage abstinence and responsibility
Increase academic success with those at-risk of dropping out
Increase communication with parents
Provide age-appropriate comprehensive health education for all students in K-12th grade, including sexuality, healthy relationships, and parenting
Provide information about and access to healthcare services
Provide many positive opportunities for student involvement
Provide prevention programs, such as support groups and mentoring
Screen for high-risk behaviors and obtain services for individual needs

Voluntary Agencies should:
Educate clients on reproductive health issues
Provide best practice prevention programs
Provide care management services for individuals and families
Provide parent education
Provide resource information for clients
Seize all opportunities to educate and encourage individual responsibility
Sponsor media prevention campaigns

IX. Inventory of Resources Available in the Community

From the staff survey and community forum, information on the prevention services and resources available at SRHD and in the community was requested. Many indicated they were unaware of the resources for pregnancy prevention and mentioned that medical service directories rarely indicate the scope of family planning services available. From this feedback, the Unintended Pregnancy Prevention Team compiled a directory of primary and secondary services. The document includes community social services, medical services (low cost clinics, emergency contraceptive providers, an incentive program, and health insurance resources), and a description of Spokane Regional Health District services. Information was gathered from the 1999 Head Start directory, program brochures, and SRHD program staff. This document should be distributed to all SRHD staff and updated annually. The document should also be distributed in the community as a resource.

In general, it appears that services are not well coordinated. A seamless system of care would be beneficial to the public with linkages made between service providers. There appears to be more services for adolescents than there are for individuals in their twenties. Many community partnerships could be explored to develop and expand services to meet the needs identified in this report.

X. Summary of Identified Gaps in Community

From the previous chapters in this report and the input gained from the literature, staff survey, team discussions, and the community forum, a list of identified gaps has been compiled. Target populations identified in the community include adolescents, young adults, males, and the general public. Primary prevention of pregnancy is important, but more should be done on secondary pregnancy prevention, also, and the spacing of children for optimal health.

Education and Programs

In general, there is a lack of knowledge and awareness around unintended pregnancy issues, including:

- Concept of unintended and intended pregnancy
- Contraception, risks and benefits, and types, including emergency contraceptives
- Effects of substance use on decision-making regarding sexual behavior
- Exploitation issues displayed in media and older male involvement with younger females
- Goal-setting and life planning
- Healthy relationships
- Individual and community awareness of reproductive health and available resources
- Individual responsibility for behavior and the consequences
- Parent-child communication and role modeling around healthy sexual behavior
- Parenting practices that provide structured supervised time, positive activities
- Relation between sexual abuse and unintended pregnancy

Missed opportunities are apparent where information could be provided or programs implemented that address unintended pregnancy prevention. High quality instruction on sexuality and contraception is not uniformly available in the community. Research has demonstrated primary and secondary prevention programs must provide outreach to high-risk individuals with long-term involvement with those individuals.

Healthcare Services

From the research, staff survey, community input, and state and national objectives, prevention efforts to reduce unintended pregnancy must have a strong healthcare component. An integrated, comprehensive and seamless service delivery system that is timely, provides confidential access, and incentives to the general public with extra efforts made to provide outreach to underserved populations reduces unintended pregnancies. The following must be addressed in the service system:

- Access to permanent methods
- Missed opportunities and one-stop service
- Assistance with compliance regimens of some contraceptives
- Care management services to provide follow-up to high-risk populations
- Choices and contraceptive counseling addressing age-appropriate sexual behavior
- Education to reduce contraceptive user failure and technical method failure
- Increased access to comprehensive reproductive healthcare services (longer hours, more sites), including lower cost to no cost birth control

- Insurance coverage of birth control and comprehensive family planning services for all regardless of medical plan
- Mental health counseling services
- Needs met of individuals uninsured, on Medicaid or private insurance
- Two year Medicaid coverage postpartum for 185 percent of poverty level up to 200 percent

Media

The media-related gaps are the following:

- Lack of information about sexual health and sexuality issues provided to general public
- Lack of healthy sexuality messages, including information about available resources
- Lack of balanced messages to counter negative sexual representation in television shows

Personal Beliefs and Attitudes

One of the aspects of unintended pregnancy that continues to come out as a huge factor impacting behavior and utilization of means to prevent pregnancy are personal beliefs and attitudes. Individuals hold a wide range of personal feelings and attitudes around planning their families and the concept of intended pregnancies. There is a lack of understanding around the benefits of planning a pregnancy and the costs of unintended pregnancy. Partners influence sexual decision-making greatly as well as the quality of the relationship and trust/respect issues. The comfort level of couples discussing their sexuality varies, often hindering open communication. There are varying feelings about contraceptive methods themselves. Risk-taking behaviors of youth, young adults, substance-using individuals, and others have consequences that are often not thought out. The other huge factors playing into unintended pregnancy prevention are the socioeconomic and cultural influences including: Cultural values; religious and political preferences; content of the media; economic issues; race/gender bias; violence against women; and opposition to abortion and some methods of contraception.

More research is needed to help us understand the impact of personal beliefs and attitudes on unintended pregnancy prevention in Spokane County.

Other

Three other gaps came out during the discussion for this project. They include:

- Alternative housing needs for adolescents living in abusive homes in Spokane County;
- Lack of stable funding for unintended pregnancy prevention in Washington State; and
- Lack of local information around cultural issues and proven best practices for reaching young adults 18-24 years of age and males in various age groups.

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Appendix A: Staff Survey

Unintended Primary and Secondary Pregnancy Prevention Services

Survey for SRHD Employees

Definition: Unintended pregnancy prevention is the prevention of primary and secondary pregnancies to women of all ages - teens (12 – 19 years of age) and adults (20 and over). Secondary prevention includes those individuals who have been pregnant, regardless of the outcome (aborted, miscarried, parenting, or relinquished).

1. Do you provide services to individuals who are at-risk of becoming pregnant unintentionally? Please circle one answer. Yes No

   If the answer is no, skip to question 5.

2. What services do you currently provide these individuals to help them make decisions and prevent an unintended pregnancy? Please provide detail.

3. What other pregnancy prevention services at SRHD are you aware of and can refer at-risk individuals to? Bullet answers below. Use back of survey, if needed.

4. What services do you refer these individuals to in the community to help them in their reproductive decision-making? Check those that apply. Write in specific answers, if requested. Use back of survey, if needed.

   - ☐ Community Clinics, i.e. CHAS
   - ☐ Community Service Offices (CSO's)
   - ☐ Hospital Service
   - _____
   - ☐ Life Services (Crisis Pregnancy Cntr.)
   - ☐ Planned Parenthood
   - ☐ Private Physicians
   - ☐ SRHD Clinic
   - ☐ Teen-Aid
   - ☐ Other_____
     _____
     _____
     _____
     _____
     _____
     _____
     _____

5. In your opinion, what additional services do you feel the community should provide the following groups to help them with reproductive decision-making? Please provide detail. Use back of page, if needed.

Uninsured/Underinsured

Adults:

Teens:

Insured (Medicaid, Private)

Adults:

Teens:

6. Out of those services that you listed under question 5, what do you think would be the appropriate role for public health to take?

7. What information or resources would be helpful to you in fulfilling our public health role of preventing unintended pregnancies?

Please return survey to room 401.

Appendix B: Washington State Organizations Interested in Unintended Pregnancy Prevention

Bremerton-Kitsap County Public Health Department
Community Trade and Economic Development
Group Health Cooperative
Healthy Mothers, Healthy Babies
Molina
Northwest Emergency Contraception Coalition (NWECC)
Office of Superintendent of Public Instruction
Program for Appropriate Technology in Health
Public Health of Seattle/Kind County
University of Washington Department of Pharmacy
Washington Association of Community and Migrant Health Centers
Washington State Department of Health
Washington State Pharmacists Association
Washington State, Department of Social and Health Services, Economic Services Administration/Child Support Division
Washington State, Department of Social and Health Services, Medical Assistance Administration/Family Planning

This list is not inclusive.

Appendix C: National Goals and Objectives

To achieve the overall goal of improving pregnancy planning and spacing and prevent unintended pregnancy, the ***Healthy People 2010 objectives*** include:

1. Increase the proportion of pregnancies that are intended.
2. Reduce the proportion of births occurring within 24 months of a previous birth.
3. Increase the proportion of females at risk of unintended pregnancy and their partners who use contraception.
4. Reduce the proportion of females experiencing pregnancy despite use of a reversible contraceptive method.
5. Increase the proportion of health care providers who provide emergency contraception.
6. Increase male involvement in pregnancy prevention and family planning efforts.
7. Reduce pregnancies among adolescent females.
8. Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years.
9. Increase the proportion of adolescents who have never engaged in sexual intercourse.
10. Increase the proportion of sexually active, unmarried adolescent aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease.
11. Increase the proportion of young adults who have received formal instruction before turning age 18 years on reproductive health issues, including all of the following topics: birth control methods, safer sex to prevent HIV, prevention of sexually transmitted diseases, and abstinence.
12. Reduce the proportion of married couples whose ability to conceive or maintain a pregnancy is impaired.
13. Increase the proportion of health insurance policies that cover contraceptive supplies and services.

Other related objectives focus on access to quality health services, educational and community-based programs, health communication, HIV, cancer, and immunization/infectious diseases, injury and violence prevention, maternal, infant, and child health, nutrition and overweight, sexually transmitted diseases, and substance abuse.

The U.S. Department of Health and Human Services, Health Resources and Services Administration and the National Association of County and City Health Officials published *Unintended Pregnancy: Prevention Strategies for Local Health Departments in 1996.* The document outlined five goals with action steps:

1. Improve knowledge about contraception and reproductive health
2. Increase access to contraception.
3. Explicitly address the major roles that feelings, attitudes, and motivation play in using contraception and avoiding unintended pregnancy.

4. Develop and scrupulously evaluate a variety of local programs to reduce unintended pregnancy.
5. Stimulate research to develop new contraceptive methods for both women and men, answer important questions about how best to organize contraceptive services, and understand more fully the determinants and antecedents of unintended pregnancy.